Morning Glory Counseling

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Consent for Treatment

The Counseling Process

The purpose of psychological treatment is to improve our overall emotional and mental wellbeing. It is important to understand that the therapy process entails both benefits and risks. Through therapy, growth and healing is very possible and can produce incredible results. There is potential for a reduction of symptoms, as well as feelings of relief and improved interpersonal relationships. However, it is important to be aware that change often cannot occur without confronting some difficult experiences and emotions. Thus, therapy may temporarily increase some of the very symptoms you are trying to reduce on the road to healing. In other words, it may get worse before it gets better. Additionally, even positive change can affect your life and relationships in unexpected ways. For example, one risk to couples counseling is the possibility of exercising the dissolution option. These are natural occurrences in therapy and something that we will work through together.

Any goals for therapy and/or decisions you make to facilitate change are ultimately up to you. Some clients need only a few sessions to achieve their goals; others may require months or even years. We will work in collaboration to create a treatment plan to best meet your needs, and although recommendations will be made to you, you have every right to decline or disregard any recommendations you do not find helpful.

Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment, and/or services, and authorize the undersigned therapist to provide such assessment, care, treatment, and/or services, as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, and/or services.

<u>Attendance and Participation</u>

- I understand that my initial session is for assessment purposes only and is not a guarantee of a continued therapeutic relationship.
- I understand that I may inquire about techniques, approaches, and the therapy process at any time. If there are needs identified that my therapist cannot provide, she will assist me in finding the most appropriate resources.
- I understand that I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from therapy.
- I understand that I may stop therapy received through the undersigned therapist at any time and for any reason, without any additional moral, legal, or financial obligation. I understand that I may be asked to participate in a termination session upon termination of counseling services.
- I understand that I will not attend a session if I am ***under the influence of alcohol or drugs***, or if I am ***in possession of a dangerous weapon.***

<u>No-Show and Termination of Treatment Policy</u>

- A "No Show" is defined as an appointment that is missed without any communication, OR as an appointment that is canceled without 24-hour notice.
- Either I or the therapist may choose to terminate the therapeutic relationship at any time. If the therapist terminates the relationship, I will be provided with referrals for more appropriate services should they be needed.

- If I miss a scheduled appointment without notice ("No Show"), I understand that any subsequent scheduled appointments may **automatically be canceled**. If I wish to reschedule, I understand that original appointment time(s) may no longer be available.

- Again, I understand that I may stop therapy at any time and for any reason, but I may be asked to participate in a termination session upon termination of counseling services.

- If I do not receive treatment for 90 days, I understand my chart will be considered closed and I will no longer be under the care of this therapist or Morning Glory Counseling until I request for my chart to be reopened and resume therapy.

Confidentiality

All of our communications over the course of therapy becomes part of my **protected health information**, recorded in my clinical record, which will remain confidential and stored securely. The personnel in this office who may need to access my file for administrative purposes are also bound by confidentiality. My clinical record is the property of Morning Glory Counseling. State and federal law protect the therapy process and the information disclosed within the helping relationship as confidential. My sharing with the therapist in therapy is respected as private. The therapist will always be clearly conscious of protecting my confidentiality. All information, including the clinical record kept of our helping relationship and what I tell the therapist, is also protected by the ethical standards of the mental health profession.

I am aware of the following **Exceptions to Confidentiality:**

1. I provide written consent to release my records or to share information regarding my treatment*;
2. I am at risk of imminent serious harm to myself or others**;
3. A medical emergency;
4. I disclose abuse, neglect, or exploitation of a child, elderly, or a disabled person;
5. I disclose sexual misconduct of a physician or therapist/social worker;
6. Information is requested by my insurance company pertinent to processing claims for payment;
7. If my treatment would benefit from my therapist processing my case with other mental health professionals *(I am aware my name and specific identifying information about me will not be shared);*
8. A court order is received to disclose information (e.g. child custody or mental competency cases);
9. I file a complaint with a licensing board or in cases of a malpractice suit or legal action; records will be released to the Board and/or legal counsel;
10. I endanger my therapist or their family.

** In the event of couples' counseling, if one party requests or subpoenas joint therapy records in the future, written authorization from both parties or a court order is required.*
*** In the event that I am deemed an imminent danger to myself or others, my counselor has a professional duty to contact the proper authorities.* ***Medical and/or law enforcement officials may be notified with or without my consent.***

Although our sessions may be intimate psychologically, ours is a professional relationship rather than a social one. If the therapist sees me in public, they will protect my confidentiality by acknowledging me *only if I approach them first*. Additionally, confidentiality of information shared by electronic media, email, telemedicine, phone or text cannot be guaranteed. Our contact will be limited to counseling sessions I arrange with the therapist. In the event of a mental health emergency after business hours, I may contact 911 or go to the nearest Emergency Room.

Fee Agreement & Cancellations

Sessions are usually held for approximately 50 minutes (one "therapy hour"). Fees are due when services are rendered. The hourly fee ranges from $125 to $150 per therapy hour depending on the services provided. Because our time is very precious, a 24-hour advanced notice is expected of any scheduled session that will be missed. Unless waived by mutual agreement on a case-by-case basis, notification of missed/cancelled sessions in less than 24 hours advance notice will result in a fee being charged for the missed session at the rate of a regular 50 minute session.

- **Cancellation Fees:** ***I am aware that my insurance does NOT cover Late Cancellation/No-Shows and I am expected to pay out-of-pocket for these services.*** Payment will be due prior to my next appointment and no further sessions will be scheduled until all my financial responsibilities are met or a payment plan is in place. This policy is not meant to be punitive, but appointment times I schedule are reserved for me at the exclusion of others who may be waiting to see the therapist. Cancellations may be made by email, text and/or voice mail message at (972)850-8751 to avoid charges for a missed session.

- **Email & Text:** Email and text correspondence are only for scheduling and rescheduling of appointments. I understand that if email or text is used to communicate other information to include clinical issues, I will be charged a $10 fee. I understand that the therapist's email is HIPAA compliant, but text messages are not. It is best for clinical information to be shared in person.

- **Phone Calls/Phone Sessions:** Phone calls (outside of the initial phone consultation) that go beyond 15 minutes are considered to be a phone session and a prorated fee will be charged. If it is a full phone session, it will be charged the regular session fee for a 50-minute therapy hour. I understand that confidentiality cannot be guaranteed by phone. I consent to therapy by phone when appropriate.

- **Legal Fees:** Any request or requirement for the therapist to participate in legal issues in any capacity on my behalf or that of my family will be billed to me at the rate of $350.00 per hour (i.e. court appearances, writing letters/recommendations to courts or attorneys, writing reports or summaries of treatment for the courts or other legal purposes, issues concerning employer-employee, or on bargaining agency-union issues) no matter which attorney issues a subpoena. If documents are required within 3 days of request, I agree to pay a $350 administration fee for expedited services.

- **Books & Resources:** I agree to return all loaned resources (books, videos, or other media) or pay the replacement cost of the resource.

Death or Incapacity

In the event that the therapist dies or is otherwise incapable of providing for the clinical services of this office, I consent for the therapist to designate a colleague(s) as conservator for the records of this office, including all my records. At the time of death or incapacity of the therapist, the colleague(s) will take possession of my records and make those available to me or to another mental health professional of my choosing at such time that a written request is made to the office.

Referrals and Complaints

Not all conditions presented by clients are appropriate for treatment at this office. If it happens that within the course of therapy, an issue arises that lies outside the realm of the therapist's scope of professional competency, they will discuss any issues with me and provide referral sources. A verbal and/or written exploration of alternatives to therapy will be made available upon request. I will be responsible for contacting and evaluating those referrals and/or any other alternatives.

All services will be rendered in a professional manner consistent with accepted ethical standards. In the event that a particular dissatisfaction with any services should arise, discussion with the therapist is encouraged. If we are unable to arrive at an acceptable solution, referral sources will be provided by the therapist.

I have been notified that if the counselor is not able to resolve my concerns, I may report my complaint to the Texas State Board of Professional Counselors or Social Worker Examiners at the appropriate following address:

Texas Behavioral Health Executive Council
333 Guadalupe Street, Tower 3, Room 900
Austin, TX 78701-3183, USA
E-mail: lpc@dshs.state.tx.us
Telephone: (512) 305-7700
24-hour/toll-free complaint system: (800) 821-3205
Website: https://www.bhec.texas.gov/discipline-and-complaints/

I have read and fully understand all of the above disclosure statement and agree to the terms therein. By my signature, I verify the accuracy of this statement and acknowledge my commitment to conform to its specifications, and voluntarily agree to receive mental health treatment.

_____
Client/Guardian Name (PRINTED)

_____ _____
Client/Guardian Name (SIGNED) Date

_____ _____
Rachel D. Williams, MS, LPC, NCC Date
Owner, Morning Glory Counseling